

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2023

Version 2023.1

Updated:09-20-2022

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS			
	ANTI-INFECTIVE		Maximum Age Limit • 21 years – all agents except isotretinoins
	clindamycin gel (generic Cleocin-T) clindamycin lotion clindamycin solution	ACZONE (dapson) AKNE-MYCIN (erythromycin) azelaic acid AMZEEQ FOAM (minocycline) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDAMYCIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam clindamycin gel daily (generic Clindagel) dapsone ERY (erythromycin) ERYGEL (erythromycin) erythromycin gel, swabs, solution EVOCLIN (clindamycin) KLARON (sulfacetamide) sulfacetamide WINLEVI (clascoterone)	
	RETINOIDS		
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene)	

1

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PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

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		FABIOR (tazarotene) PLIXDA (adapalene) RETIN-A MICRO (tretinoin) tazarotene TAZORAC (tazarotene) tretinoin gel tretinoin micro TWYNEO (tretinoin/benzoyl peroxide)	
	COMBINATION DRUGS/OTHERS		
	adapalene/benzoyl peroxide (generic EPIDUO) benzoyl peroxide/clindamycin (generic DUAC) sodium sulfacetamide/sulfur foam/gel/suspension SSS 10/5 Cream (sodium sulfacetamide/sulfur)	ACANYA (benzoyl peroxide/clindamycin) adapalene/benzoyl peroxide (generic EPIDUO FORTE) AKTIPAK (erythromycin/benzoyl peroxide) BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZACLIN KIT (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE (adapalene/benzoyl peroxide) EPSOLAY (benzoyl peroxide) erythromycin/benzoyl peroxide INOVA 4/1 (benzoyl peroxide/salicylic acid) INOVA 8/2 (benzoyl peroxide/salicylic acid) NEUAC (benzoyl peroxide/clindamycin) ONEXTON (benzoyl peroxide/clindamycin) PRASCION (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur) SE BPO (benzoyl peroxide)	

2

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		sodium sulfacetamide/sulfur cleanser/cream/lotion/pads sodium sulfacetamide/sulfur/meratan SSS 10/5 Foam (sodium sulfacetamide/sulfur) sulfacetamide sodium/sulfur/urea VELTIN (clindamycin/tretinoin) ZENCIA WASH (sulfacetamide sodium/sulfur) ZIANA (clindamycin/tretinoin)	
	KERATOLYTICS (BENZOYL PEROXIDES)		
	benzoyl peroxide bar, cleanser, cream, gel, lotion, wash ^{Rx & OTC}	benzoyl peroxide foam ^{Rx & OTC} BP 5.5% (benzoyl peroxide) BPO (benzoyl peroxide) ^{Rx & OTC} INOVA (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PANOXYL BAR 10% (benzoyl peroxide) ^{OTC} PANOXYL CREAM 3% (benzoyl peroxide) ^{OTC} OC8 GEL (benzoyl peroxide) ^{OTC}	
	ISOTRETINOIN		
	ACUTANE (isotretinoin) AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN (isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin)	Available for all ages
ALPHA-1 PROTEINASE INHIBITORS			
	ARALAST (alpha-1 proteinase inhibitor) GLASSIA (alpha-1 proteinase inhibitor) PROLASTIN C (alpha-1 proteinase inhibitor) ZEMAIRA (alpha-1 proteinase inhibitor)		

3

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ALZHEIMER'S AGENTS ^{DUR+}			
	CHOLINESTERASE INHIBITORS		All Agents <ul style="list-style-type: none">• Documented diagnosis for both preferred and non-preferred Non-Preferred Criteria <ul style="list-style-type: none">• Have tried 2 different preferred agents in the past 6 months
	donepezil (tablets and ODT) 5mg, 10mg galantamine galantamine ER rivastigmine capsules rivastigmine patches	ADLARITY (donepezil) ARICEPT (donepezil) ARICEPT 23 MG (donepezil) ARICEPT ODT (donepezil) donepezil 23mg EXELON Capsules (rivastigmine) EXELON Patches (rivastigmine) EXELON Solution (rivastigmine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	
	NMDA RECEPTOR ANTAGONIST		
	memantine	NAMENDA TABS (memantine) NAMENDA SOLUTION (memantine) NAMENDA XR (memantine) memantine XR	
	COMBINATION AGENTS		Namzaric <ul style="list-style-type: none">• Documented diagnosis AND• 30 days of concurrent therapy with donepezil + memantine in the past 6 months
		NAMZARIC (memantine/donepezil)	
ANALGESICS, OPIOID- SHORT ACTING ^{DUR+}			
	acetaminophen/codeine benzhydrocodone/APAP codeine dihydrocodeine/APAP/caffeine	ABSTRAL (fentanyl) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP) butalbital/APAP/caffeine/codeine	MS DOM Opioid Initiative <ul style="list-style-type: none">• Short-Acting Opioids• Long-Acting Opioids• Morphine Equivalent Daily Dose

4

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	<p>ENDOCET (oxycodone/APAP) hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP tramadol tramadol/APAP</p>	<p>butalbital/ASA/caffeine/codeine butorphanol tartrate (nasal) DEMEROL (meperidine) DILAUDID (hydromorphone) DVORAH (dihydrocodeine/ APAP/caffeine) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/ibuprofen IBUDONE (hydrocodone/ibuprofen) LAZANDA NASAL SPRAY (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine solution meperidine tablet NALOCET (oxycodone/APAP) NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXAYDO (oxycodone) oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP)</p>	<ul style="list-style-type: none"> Concomitant use of Opioids and Benzodiazepines Criteria details found here Minimum Age Limit 18 years – tramadol and codeine products Quantity Limit Applicable <u>quantity limit</u> in 31 rolling days 62 tablets – butalbital/codeine combinations, codeine, dihydrocodeine combinations, fentanyl, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxycodone/ibuprofen, oxymorphone, pentazocine, tapentadol, tramadol 62 tablets CUMULATIVE – hydrocodone combinations, oxycodone combinations 124 tablets – butalbital/APAP 750 145 tablets – butalbital/APAP 650 186 tablets – butalbital/APAP 325, butalbital/ASA 325 5mL (2 x 2.5 bottles) – butorphanol nasal 180 mL CUMULATIVE – oxycodone liquids 280 mL CUMULATIVE – Qdolo

5

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		PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) QDOLO (tramadol) REPREXAIN (hydrocodone/ibuprofen) ROXICET (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (tramadol/celecoxib) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ aspirin/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZOLVIT (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	
ANALGESICS, OPIOID - LONG ACTING ^{DUR+}			
	BUTRANS (buprenorphine) fentanyl patches morphine ER tablets	ARYMO ER (morphine) BELBUCA (buprenorphine) buprenorphine patch CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EMBEDA (morphine/naltrexone) EXALGO (hydromorphone)	MS DOM Opioid Initiative <ul style="list-style-type: none"> • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines Criteria details found here

6

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		hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone MORPHABOND (morphine) morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/APAP) XTAMPZA (oxycodone myristate) ZOHYDRO ER (hydrocodone bitartrate)	Minimum Age Limit <ul style="list-style-type: none"> • 18 years – Butrans, Xartemis XR, Zohydro ER, tramadol products Quantity Limit Applicable <u>quantity limit</u> per rolling days <ul style="list-style-type: none"> • 31 tablets/31 days - Conzip ER, Exalgo ER, Hysingla ER, Ryzolt, Ultram ER • 62 tablets/31 days – Arymo ER, Belbuca, Embeda, Kadian, methadone, Morphabond, morphine ER, Nucynta ER, Opana ER, oxycodone ER, Oxycontin, Xtampza ER, Zohydro ER • 10 patches/31 days – Duragesic • 4 patches/31 days – Butrans • 40 tablets/10 days – Xartemis XR Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • Documented diagnosis of cancer OR Antineoplastic therapy AND • 90 consecutive days on the requested agent in the past 105 days
ANALGESICS/ANESTHETICS (Topical)			

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	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 5% ointment VOLTAREN Gel (diclofenac sodium) ^{DUR+}	capsaicin diclofenac epolamine patch ^{DUR+} diclofenac sodium 3% gel FLECTOR Patch (diclofenac epolamine) ^{DUR+} FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) lidocaine 5% patch lidocaine/prilocaine LIDODERM (lidocaine) ^{DUR+} LIDTOPIC MAX (lidocaine) PENNSAID 2% Solution (diclofenac sodium) ^{SmartPA} SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) VENNGEL ONE 1% kit (diclofenac sodium) XRYLIDERM (lidocaine) xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 preferred agent in the past 6 months Lidoderm <ul style="list-style-type: none"> Documented diagnosis of Herpetic Neuralgia OR Documented diagnosis of Diabetic Neuropathy ZTlido <ul style="list-style-type: none"> Documented diagnosis of Herpetic Neuralgia
ANDROGENIC AGENTS ^{DUR+}			
	ANDRODERM (testosterone patch) testosterone gel packet	ANDROGEL (testosterone gel) ANDROXY (fluoxymesterone) AXIRON (testosterone gel) FORTESTSA (testosterone gel) JATENZO (testosterone undecanoate) NATESTO (testosterone)	All Agents <ul style="list-style-type: none"> Limited to male gender Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months

8

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		STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	
ANGIOTENSIN MODULATORS ^{DUR+}			
	ACE INHIBITORS		
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril trandolapril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS (lisinopril) UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	Minimum Age Limit <ul style="list-style-type: none"> • ≤ 6 years – Epaned Dur + <u>will automatically be issued for this age</u> Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred <u>single entity</u> agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
	ACE INHIBITOR COMBINATIONS		
	benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRESTALIA (perindopril/amlodipine)	Non-Preferred Criteria ACE Inhibitor/CCB <ul style="list-style-type: none"> • Have tried 2 different preferred <u>ACEI/CCB</u> agents in the past 6 months OR

9

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	quinapril/HCTZ trandolapril/verapamil	PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <p>ACE Inhibitor/Diuretic</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>ACEI/Diuretic</u> agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)			
	irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) TEVETEN (eprosartan)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>single entity</u> agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ARB COMBINATIONS			
	ENTRESTO (valsartan/sacubitril) ^{DUR +} irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ telmisartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ	<p>Entresto</p> <ul style="list-style-type: none"> Age ≥ 18 years AND Documented diagnosis of heart failure OR Age ≥ 1 year AND

10

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	valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWINSTA (telmisartan/amlodipine)	<ul style="list-style-type: none"> Documented diagnosis of heart failure with systemic ventricular systolic dysfunction <p>Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic</p> <ul style="list-style-type: none"> Have tried 1 preferred <u>ARB/CCB</u> agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days <p>ARB/Diuretic</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>ARB/Diuretic</u> products in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
DIRECT RENIN INHIBITORS			
		TEKTURN (aliskiren)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of hypertension AND Have tried 2 different preferred <u>ACEI or ARB single-entity</u> products in the past 6 months OR

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			<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days
	DIRECT RENIN INHIBITOR COMBINATIONS		
		AMTURNIDE (aliskiren/amlodipine/hctz) TEKAMLO (aliskiren/amlodipine) TEKTRNA-HCT (aliskiren/hctz) VALTRNA (aliskiren/valsartan)	Non-Preferred Criteria <ul style="list-style-type: none"> Documented diagnosis of hypertension AND Have tried 2 different preferred <u>ACEI or ARB diuretic agents</u> in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ANTIBIOTICS (GI)			
	FIRVANQ (vancomycin) metronidazole neomycin tinidazole	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) paromomycin TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
	KETOLIDES		
		KETEK (telithromycin)	
	LINCOSAMIDE ANTIBIOTICS		

12

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	clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)	
	MACROLIDES		
	azithromycin clarithromycin ER clarithromycin IR clarithromycin suspension ERY-TAB (erythromycin) erythromycin erythromycin ethylsuccinate	BIAXIN (clarithromycin) BIAXIN SUSPENSION (clarithromycin) BIAXIN XL (clarithromycin) E.E.S. FILM TAB (erythromycin ethylsuccinate) E.E.S. Suspension (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED Suspension (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
	NITROFURAN DERIVATIVES		
	nitrofurantoin nitrofurantoin monohydrate macrocrystals	FURADANTIN (nitrofurantoin) MACROBID (nitrofurantoin monohydrate macrocrystals) MACRODANTIN (nitrofurantoin)	
	OXAZOLIDINONES		
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	Sivextro – MANUAL PA Zyvox - MANUAL PA Quantity Limit

13

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			• 6 tablets/month – Sivextro
	PLEUROMUTLINS		
		XENLETA (lefamulin)	
ANTIBIOTICS (Topical)			
	bacitracin ^{OTC} bacitracin/polymyxin ^{OTC} gentamicin sulfate mupirocin ointment neomycin/bacitracin/polymyxin ^{OTC}	ALTABAX (retapamulin) CORTISPORIN (bacitracin/neomycin/ polymyxin/Hc) mupirocin cream NEOSPORIN (neomycin/bacitracin/polymyxin) ^{OTC} XEPI (ozenoxacin)	
ANTIBIOTICS (VAGINAL)			
	CLEOCIN OVULES (clindamycin) CLINDESSE (clindamycin) metronidazole vaginal	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole)	
ANTICOAGULANTS ^{DUR+}			
	ORAL		
	COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	BEVYXXA (betrixaban) SAVAYSA (edoxaban tosylate)	<u>DVT Prophylaxis - following hip replacement</u> XARELTO 10MG, ELIQUIS, PRADAXA 110MG • 70 total days of therapy per calendar year

14

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			<ul style="list-style-type: none"> Documented diagnosis of hip replacement AND Duration of therapy limited to 35 days <p>DVT Prophylaxis - following knee replacement XARELTO 10MG & ELIQUIS</p> <ul style="list-style-type: none"> 70 total days of therapy per calendar year Documented diagnosis of knee replacement AND Duration of therapy limited to 12 days <p>Eliquis 5mg Starter Pack - ONLY approved for treatment of DVT/PE</p> <p>XARELTO 2.5MG</p> <ul style="list-style-type: none"> Documented diagnosis of coronary artery disease OR Documented diagnosis of peripheral artery disease AND History of therapy with aspirin in the past 30 days AND History of 90 days therapy with anti-platelet agent in the past year OR History of 30 days therapy with warfarin in the past year

15

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			Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 1 claim with the requested agent in the past 90 days
	LOW MOLECULAR WEIGHT HEPARIN (LMWH)		
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	LMWH – All Agents <ul style="list-style-type: none"> LMWH therapy in the past 3 months AND <ul style="list-style-type: none"> Documented diagnosis of cancer OR Female and age 8 to 51 years OR NO LMWH therapy in the past 3 months AND <ul style="list-style-type: none"> Duration of therapy is ≤ 17 days OR Documented diagnosis of cancer OR Female age 8 to 51 years OR Total hip/knee replacement or hip fracture surgery in the past 6 months AND Duration of therapy ≤ 35 days LMWH Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 different preferred agent in the past 6 months OR

16

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			<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days
ANTICONVULSANTS DUR+			
	ADJUVANTS		
	carbamazepine carbamazepine suspension carbamazepine ER DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin GABITRIL (tiagabine) lacosamide lamotrigine levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DIACOMIT (stiripentol) ELEPSIA XR (levetiracetam) EPRONTIA (topiramate solution) EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER/XR lamotrigine ODT	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 1 year – Banzel, Epidiolex 2 years – Diacomit, Onfi, Sympazan <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p>Banzel, Onfi, Sympazan</p> <ul style="list-style-type: none"> Documented diagnosis of Lennox-Gastaut AND Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p>Diacomit</p>

17

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		NEURONTIN (gabapentin) OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX TABLET (topiramate) TOPAMAX Sprinkle (topiramate) topiramate ER (generic Qudexy XR) ^{Step Edit} TRILEPTAL Tablets (oxcarbazepine) TRILEPTAL Suspension (oxcarbazepine) TROKENDI XR (topiramate) vigabatrin VIMPAT (lacosamide) XCOPRI (cenobamate)	<ul style="list-style-type: none"> Documented diagnosis of Dravet syndrome AND Active claim for clobazam <p>Epidiolex</p> <ul style="list-style-type: none"> Documented diagnosis of Dravet syndrome or seizures associated with tuberous sclerosis complex OR Documented diagnosis of Lennox-Gastaut OR 1 claim for the requested agent in the past 30 days <p>Fintepla</p> <ul style="list-style-type: none"> Requires clinical review <p>Sabril Powder for Oral Solution</p> <ul style="list-style-type: none"> Documented diagnosis of infantile spasms OR Have tried 2 different preferred agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p>Topiramate ER – Step Edit</p> <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days AND

18

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			<ul style="list-style-type: none"> Documented diagnosis of seizure OR 30-day trial with topiramate IR in the past 6 months
	SELECTED BENZODIAZEPINES		
	clobazam diazepam rectal gel NAYZILAM (midazolam) VALTOCO (diazepam)	DIASTAT (diazepam rectal) DIASTAT ACCUDIAL (diazepam rectal) ONFI (clobazam) ONFI SUSPENSION (clobazam) SYMPAZAN (clobazam)	Minimum Age Limit <ul style="list-style-type: none"> 12 years – Nayzilam 6 years – Valtoco Quantity Limit <ul style="list-style-type: none"> 2 Twin Packs/31 days – Diastat 2 Packages /31 days – Nayzilam 2 Cartons/31 days - Valtoco
	HYDANTOINS		
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
	SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	
ANTIDEPRESSANTS, OTHER ^{DUR+}			

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	bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules VIIBRYD (vilazodone)	APLENZIN (bupropion HBr) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine DR) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal) FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine) tranylcypromine venlafaxine XR venlafaxine ER tablets WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion HCl)	Minimum Age Limit <ul style="list-style-type: none"> • 18 years - all drugs • 7-17 years – duloxetine (except Drizalma Sprinkle) <i>Dur + will automatically be issued for this age range with a diagnosis of GAD (generalized anxiety disorder)</i> • 7-11 years – Drizalma Sprinkle <i>Dur + will automatically be issued for this age range with a diagnosis of GAD (generalized anxiety disorder)</i> Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred <i>'Antidepressants, Other' Class</i> in the past 6 months OR • Have tried BOTH a preferred <i>'Antidepressant, SSRI' and 'Antidepressants, Other'</i> in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days Cymbalta and Irenka (see Fibromyalgia Agents)
ANTIDEPRESSANTS, SSRIs ^{DUR+}			
	citalopram	CELEXA (citalopram) fluoxetine DR	Minimum Age Limit

20

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	escitalopram fluoxetine capsules fluvoxamine paroxetine CR paroxetine IR sertraline	fluvoxamine ER LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	<ul style="list-style-type: none"> • 6 years - Zoloft • 7 years – Prozac • 8 years - Luvox • 12 years - Lexapro • 18 years – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg <p>Citalopram Criteria</p> <ul style="list-style-type: none"> • <18 years and 90 consecutive days on citalopram in the past 105 days OR • < 60 years AND max daily dose ≤ 40 mg/day OR • ≥ 60 years AND max daily dose ≤ 20 mg/day <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
ANTIEMETICS DUR+			
	5HT3 RECEPTOR BLOCKERS		
	ondansetron ondansetron ODT ondansetron solution	ANZEMET (dolasetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron)	<p>Quantity Limit</p> <ul style="list-style-type: none"> • 6 tablets/31 days – Akynzeo • 30 tablets/31 days – Zofran tablets/ODT • 100 ml/31 days – Zofran solution

21

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		ZUPLENZ (ondansetron)	Non-Preferred Agents <ul style="list-style-type: none">Have tried 1 preferred agent in the past 6 months <p>Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital</p>
	ANTIEMETIC COMBINATIONS		Akynzeo - MANUAL PA
		AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	
	CANNABINOIDS		
		CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
	NMDA RECEPTOR ANTAGONIST		
	EMEND (aprepitant)	aprepitant	
ANTIFUNGALS (Oral) ^{DUR+}			
	clotrimazole fluconazole griseofulvin microsize suspension nystatin terbinafine	ANCOBON (flucytosine) ^ BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V (griseofulvin, microsize) griseofulvin microsize tablets	Minimum Age Limit <ul style="list-style-type: none">4-12 years – Lamisil Granules <u>Dur + will automatically be issued for this age range</u>12-17 years – griseofulvin tablets <u>Dur + will automatically be issued for this age range</u>

22

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		griseofulvin ultramicrosize tablet GRIS-PEG (griseofulvin) itraconazole ^ ketoconazole LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^ posaconazole ^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ voriconazole ^	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months HIV opportunistic infection <ul style="list-style-type: none"> Non-Preferred agent indicated for treatment (^) AND Documented diagnosis of HIV Cresemba - <u>MANUAL PA</u> <ul style="list-style-type: none"> Minimum age limit > 18 years AND Documented diagnosis of invasive aspergillosis OR invasive mucormycosis AND Prescriber is an oncologist/hematologist or infectious disease specialist Sporanox <ul style="list-style-type: none"> HIV opportunistic infection criteria OR Documented diagnosis of a transplant OR History of an immunosuppressant in the past 6 months OR Have tried 2 different preferred agents in the past 6 months
ANTIFUNGALS (Topical) ^{DUR+}	ANTIFUNGALS		

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	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution ^{Rx & OTC} ketoconazole shampoo LUZU (luliconazole) miconazole cream/powder ^{OTC} nystatin terbinafine cream/spray ^{OTC} tolnaftate cream/powder/spray ^{OTC}	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) ketoconazole cream ketoconazole foam LAMISIL (terbinafine) solution LOPROX (ciclopirox) luliconazole MENTAX (butenafine) naftifine NAFTIN (naftifine) NIZORAL (ketoconazole) oxiconazole OXISTAT (oxiconazole) PEDIADERM AF (nystatin) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
ANTIFUNGAL/STEROID COMBINATIONS			

24

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	clotrimazole/betamethasone cream nystatin/triamcinolone	clotrimazole/betamethasone lotion LOTRISONE (clotrimazole/betamethasone)	
ANTIFUNGALS (VAGINAL)			
	clotrimazole vaginal cream ^{OTC} miconazole 1, 7cream ^{OTC} miconazole 3 vaginal cream, suppository ^{OTC} TERAZOL 3 Cream (terconazole) – currently unavailable from manufacturer terconazole cream tioconazole	GYNAZOLE 1 (butoconazole) TERAZOL 3 Suppository (terconazole) TERAZOL 7 (terconazole) terconazole suppository	
ANTI-HISTAMINES, MINIMALLY SEDATING AND COMBINATIONS ^{DUR+}			
	MINIMALLY SEDATING ANTIHISTAMINES		Non-Preferred Criteria <ul style="list-style-type: none"> • Documented diagnosis of allergy or urticaria AND • Have tried 2 different preferred agents in the past 12 months
	cetirizine tablets ^{OTC} cetirizine syrup ^{Rx & OTC} loratadine odt ^{OTC} loratadine syrup ^{OTC} loratadine tablet ^{OTC}	cetirizine chewable ^{OTC} CLARINEX (desloratadine) desloratadine ODT desloratadine tablet fexofenadine syrup fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)	
	MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS		

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	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, ACUTE TREATMENT			
	CGRP ORAL		
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Nurtec ODT, Ubrelvy <p>Quantity Limit</p> <ul style="list-style-type: none"> • 8 tablets/31 day – Nurtec ODT • 16 tablets/31 day – Ubrelvy <p>Nurtec ODT</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 6 months AND • No concurrent therapy with another CGRP agent <p>Ubrelvy</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 6 months AND

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			<ul style="list-style-type: none"> Have tried preferred Nurtec ODT in the past 6 months AND No concurrent therapy with another CGRP agent AND No concurrent therapy with a strong CYP3A4 inhibitor
	TRIPTANS & RELATED AGENTS ORAL ^{DUR+}		
	naratriptan rizatriptan rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAK (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	<p>Minimum Age Limit – ALL FORMULATIONS</p> <ul style="list-style-type: none"> 6 years – Maxalt 12-17 years – Axert, Treximet, Zomig nasal spray <u><i>Dur + will automatically be issued for this age range</i></u> 18 years – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace Symtouch, Zomig tablets <p>Quantity Limit - ORAL</p> <ul style="list-style-type: none"> 4 tablets/31 days – Reyvow 50 mg 6 tablets/31 days - Axert, Relpax Zomig 8 tablets/31 days – Reyvow 100 mg 9 tablets/31 days - Amerge, Frova, Imitrex, Treximet 12 tablets/31 days – Maxalt <p>Non-Preferred Criteria - ORAL</p>

27

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			<ul style="list-style-type: none"> Have tried 2 preferred oral agents in the past 90 days <p>Reyvow</p> <ul style="list-style-type: none"> Documented diagnosis of migraine AND Have tried 2 different triptans in the past 90 days AND Have tried preferred Nurtec ODT in the past 90 days <p>Quantity Limit - NASAL</p> <ul style="list-style-type: none"> 1 box/31 days <p>Non-Preferred Criteria - NASAL</p> <ul style="list-style-type: none"> Have tried 2 preferred oral agents in the past 90 days AND Have tried either a preferred nasal sumatriptan or injectable sumatriptan in the past 90 days <p>CUMULATIVE Quantity Limit - INJECTION</p> <p>4 injections/31 days</p>
	NASAL		
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan ZOMIG (zolmitriptan)	
	INJECTABLES		
	sumatriptan	IMITREX (sumatriptan) ZEMBRACE (sumatriptan)	
ANTIMIGRAINE AGENTS, PROPHYLAXIS			
	INJECTIBLES		
	AIMOVIG AUTOINJECTOR (erenumab-aooe) AJOVY AUTOINJECTOR (fremanezumab-vfrm) AJOVY SYRINGE (fremanezumab-vfrm)	EMGALITY PEN (galcanezumab-gnlm) EMGALITY SYRINGE (galcanezumab-gnlm) VYEPTI (eptinezumab-jjmr)	<p>Aimovig - MANUAL PA</p> <p>Ajovy - MANUAL PA</p> <p>Emgality - MANUAL PA</p> <p>Vyepti - MANUAL PA</p>

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	ORAL		
		NURTEC ODT (rimegepant) QULIPTA (atogepant)	• See Antimigraine Agents, Acute
*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS			
	AFINITOR (everolimus) BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) COTELLIC (cobimetinib) GILOTRIF (afatinib) ICLUSIG (ponatinib) imatinib mesylate IMBRUVICA (ibrutinib) INLYTA (axitinib) IRESSA (gefitinib) JAKAFI (ruxolitinib) MEKINIST (trametinib dimethyl sulfoxide) NEXAVAR (sorafenib) ROZLYTREK (entrectinib) SPRYCEL (dasatinib) STIVARGA (regorafenib) SUTENT (sunitinib) TAFINLAR (dabrafenib) TARCEVA (erlotinib) TASIGNA (nilotinib) TURALIO (pexidartinib) TYKERB (lapatinib ditosylate) vandetanib	ALECENSA (alectinib) ALUNBRIG (brigatinib) AYWAKIT (avapritinib) BALVERSA (erdafitinib) BRAFTOVI (encorafenib) BRUKINSA (zanubrutinib) CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) COPIKTURA (duvelisib) DAURISMO (glasdegib) ERIVEDGE (vismodegib) ERLEADA (apalutamide) erlotinib everolimus EXKIVITY (mobocertinib) FARYDAK (panobinostat) FOTIVDA (tivozanib) GAVRETO (pralsetinib) GLEEVEC (imatinib mesylate) GLEOSTINE (lomustine) IBRANCE (palbociclib) SmartPA IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib)	Farydak - <u>MANUAL PA</u> • Documented diagnosis of multiple myeloma AND • Used in combination with bortezomib and dexamethasone per PI AND • History of 2 prior regimens including bortezomib and an immunomodulatory agent Ibrance • Documented diagnosis of WD-DDLS for retroperitoneal sarcoma OR • All other indications evaluated through clinical review Lenvima • Documented diagnosis of thyroid cancer OR • Documented diagnosis of hepatocellular carcinoma OR

29

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	VOTRIENT (pazopanib) XALKORI (crizotinib) XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritinib)	KISQALI (ribociclib) KOSELUGO (selumetinib) lapatinib ditosylate LENVIMA (lenvatinib) ^{DUR+} LORBRENA (lorlatinib) LUMAKRAS (sotorasib) LYNPARZA (olaparib) ^{DUR+} MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide) ODOMZO (sonidegib) ONUREG (azacitidine) ORGOVYX (relugolix) PEMAZYRE (pemigatinib) PIQRAY (alpelisib) QINLOCK (ripretinib) RETEVMO (selpercatinib) RUBRACA (rucaparib) RYDAPT (midostaurin) SCEMBLIX (asciminib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TALZENNA (talazoparib) TAZVERIK (tazemetostat) TEPMETKO (tepotinib) TIBSOVO (ivosidenib) TRUSELTIQ (infigratinib) TUKYSA (tucatinib) UKONIQ (umbralisib) VERZENIO (abemaciclib) VITRAKVI (larotrectinib) VIZIMPRO (dacomitinib)	<ul style="list-style-type: none"> Documented diagnosis of renal cell carcinoma AND History of 1 claim for everolimus in the past 30 days AND History of 1 anti-angiogenic agent in the past 2 years OR All other indications evaluated through clinical review <p>Lynparza Capsules - MANUAL PA</p> <p>Lynparza Tablets</p> <ul style="list-style-type: none"> Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer AND History of platinum-based chemotherapy in the past 2 years OR All other indications evaluated through clinical review

30

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		VONJO (pacritinib) WELIREG (belzutifan) XATMEP (methotrexate) XOSPATA (gilteritinib) XPOVIO (selinexor) ZEJULA (niraparib)	
ANTIPARASITICS (Topical) ^{DUR+}			
		PEDICULICIDES	
	permethrin 1% ^{OTC} NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	XENICAL (orlistat) Minimum Age/Weight Limit for Pediculicides <ul style="list-style-type: none"> • 50 kg - lindane shampoo • 2 months – permethrin 1%(OTC) • 6 months – Natroba, Sklice • 2 years – piperonyl/pyrethrins (OTC) • 6 years – Ovide Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 preferred topical lice agents in the past 90 days
		SCABICIDES	
	permethrin 5% ivermectin	ELIMITE (permethrin) EURAX CREAM (crotamiton) EURAX LOTION (crotamiton) STROMEKTOL Tablet (ivermectin)	Minimum Age/Weight Limit for Topical Scabicides <ul style="list-style-type: none"> • 50 kg - lindane lotion • 2 months – permethrin 5% • 4 years - Natroba • 18 years – Eurax Non-Preferred Criteria

31

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			<ul style="list-style-type: none">History of permethrin 5% in the past 90 days
ANTIPARKINSON’S AGENTS (Oral) ^{DUR+}			
	ANTICHOLINERGICS		Non-Preferred Criteria <ul style="list-style-type: none">Documented diagnosis of Parkinson’s disease ANDHave tried 2 different preferred agents in the past 6 months OR90 consecutive days on the requested agent in the past 105 days
	benztropine trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone	
	DOPAMINE AGONISTS		
	ropinirole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
	MAO-B INHIBITORS		

32

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	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline)	Xadago <ul style="list-style-type: none"> Documented diagnosis of Parkinson's disease AND History of a preferred carbidopa/levodopa combination product in the past 30 days AND History of selegiline product in the past 45 days
		OTHERS	
	amantadine bromocriptine carbidopa levodopa/carbidopa	DUOPA (levodopa/carbidopa) GOCOVRI (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY ER (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SINEMET CR (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone)	Lodosyn and Inbrija <ul style="list-style-type: none"> Documented diagnosis of Parkinson's disease AND History of a carbidopa/levodopa combination product in the past 45 days Nourianz <ul style="list-style-type: none"> Documented diagnosis of Parkinson's Disease AND History of a preferred carbidopa/levodopa combination product in the past 30 days AND History of 30 days therapy with a preferred adjunctive therapy in the past 45 days
ANTIPSYCHOTICS DUR+			
		ORAL	
	amitriptyline/perphenazine aripiprazole clozapine	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine)	Minimum Age Limit <ul style="list-style-type: none"> 2 years – Droperidol 3 years – Haldol

33

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	fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT SAPHRIS (asenapine) thioridazine thiothixene trifluoperazine ziprasidone	aripiprazole solution aripiprazole ODT asenapine CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) HALDOL (haloperidol) INVEGA ER (paliperidone) LATUDA (lurasidone) LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin) olanzapine/fluoxetine paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clonazepam) VRAYLAR (cariprazine) ZYPREXA (olanzapine)	<ul style="list-style-type: none"> • 5 years – Risperdal, thioridazine • 6 years – Abilify, trifluoperazine • 10 years – Latuda, Saphris, Seroquel, Symbyax • 12 years – Invega, Molidone, perphenazine, pimozole, thiothixene • 13 years – Zyprexa • 18 years – Abilify Mycite, Amitriptyline/perphenazine, Caplyta, Clozaril, Fanapt, fluphenazine, Geodon, loxapine, Nuplazid, Rexulti, Secuado, Vraylar <p>Concurrent Therapy Limit – Ages 0-17 years</p> <ul style="list-style-type: none"> • 90 days with >2 antipsychotics in the last 120 days will require a Manual PA <p>Non-Preferred Criteria- Atypical Agents</p> <ul style="list-style-type: none"> • Have tried 2 preferred atypical antipsychotic agents in the past 12 months OR • 30 consecutive days on the requested atypical agent in the past 180 days <p>Nuplazid</p>

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			<ul style="list-style-type: none"> Documented diagnosis of Parkinson's disease
	INJECTABLE, ATYPICALS ^{DUR+}		
	ABILIFY MAINTENA (aripirazole) ARISTADA ER (aripirazole lauroxil) ARISTADA INITIO (aripirazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone)	ABILIFY (aripirazole) GEODON (ziprasidone) olanzapine ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine)	Minimum Age Limit <ul style="list-style-type: none"> 18 years – all injectable agents Quantity Limit <ul style="list-style-type: none"> 3 syringes/year – Aristada Initio Long-Acting Injectable Agents All Agents <ul style="list-style-type: none"> Documented diagnosis of schizophrenia or schizoaffective disorder Abilify Maintena or Risperdal Consta <ul style="list-style-type: none"> Documented diagnosis of schizophrenia or schizoaffective disorder OR Documented diagnosis of bipolar disorder
	TRANSDERMAL, ATYPICALS		
		SECUADO (asenapine)	
ANTIRETROVIRALS ^{DUR+}			
	SINGLE PRODUCT REGIMENS		
	BIKTARVY (bictegravir/emtricitabine/tenofovir) CABENUVA (cabotegravir/rilpivirine) DELSTRIGO (doravirine/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) efavirenz/lamivudine/tenofovir	Stribild – <u>MANUAL PA</u> <ul style="list-style-type: none"> Genotype testing supporting resistance to other regimens OR

35

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	DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir labeler GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) JULUCA (dolutegravir/rilpivirine) ODEFSEY (emtricitabine/rilpivirine/tenofovir AF) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI-LO (efavirenz/lamivudine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	efavirenz/lamivudine/tenofovir lo STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) SYMITUZA (darunavir/cobicistat/ emtricitabine/tenofovir)	<ul style="list-style-type: none"> Intolerance or contraindication to preferred combination of drugs AND Medical reasoning beyond convenience or enhanced compliance over preferred agents AND CrCl > 70mL/min to initiate therapy OR CrCl >50mL/min to continue therapy
INTEGRASE STRAND TRANSFER INHIBITORS			
	APRETUDE ER (cabotegravir) ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> 1 claim with the requested agent in the past 105 days
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)			
	abacavir sulfate EMTRIVA (emtricitabine) EMTRIVA SOLUTION (emtricitabine) lamivudine tenofovir disoproxil fumarate ZIAGEN Solution (abacavir sulfate) zidovudine	didanosine DR capsule emtricitabine EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN Tablet (abacavir sulfate)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)			

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	EDURANT (rilpivirine) efavirenz	INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) SUSTIVA (efavirenz) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	Tybost - MANUAL PA
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR			
		TYBOST (cobicistat)	
PROTEASE INHIBITORS (PEPTIDIC)			
	atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR SOLUTION (ritonavir) ritonavir	CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir) NORVIR POWDER (ritonavir) NORVIR TABLET (ritonavir) REYATAZ (atazanavir) VIRACEPT (nelfinavir mesylate)	
PROTEASE INHIBITORS (NON-PEPTIDIC)			
	PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) PREZCOBIX (darunavir/cobicistat)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS			
		SELZENTRY (maraviroc)	

37

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	ENTRY INHIBITORS – FUSION INHIBITORS		
		FUZEON (enfuvirtide)	
	COMBINATION PRODUCTS - NRTIs		
	abacavir/lamivudine CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) JULUCA (dolutegravir/rilpivirine) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & NON-NUCLEOSIDE RTIs		
	CIMDUO (lamivudine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) efavirenz/emtricitabine/tenofovir ODEFSEY (emtricitabine/rilpivirine/tenofovir AF)	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) TEMIXYS (lamivudine/tenofovir)	
	COMBINATION PRODUCTS – PROTEASE INHIBITORS		
	KALETRA (lopinavir/ritonavir)	lopinavir/ritonavi	
	CD4 DIRECTED ATTACHMENT INHIBITOR		

38

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		RUKOBIA (fostemsavir tromethamine ER)	
	CD4 DIRECTED HIV-1 INHIBITOR		
		TROGARZO (ibalizumab)	
ANTIVIRALS (Oral)			
	ANTI-CYTOMEGALOVIRUS AGENTS		
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	valganciclovir solution – automatic approval for age <12 years Prevymis Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease • ≥ 18 years AND • Post hematopoietic stem cell transplant (HSCT) within the past 28 days AND • CMV sero-positive recipient [R+] AND • NO severe (Child-Pugh Class C) hepatic impairment
	ANTI-HERPETIC AGENTS		
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTrex (valacyclovir) ZOVIRAX (acyclovir)	

39

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	ANTI-INFLUENZA AGENTS		
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENA VIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
AROMATASE INHIBITORS			
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	

40

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ATOPIC DERMATITIS <small>DUR+</small>			
	ADBRY (tralokinumab) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 2 years – Elidel, Protopic 0.03% • 6 years – Protopic 0.1% <p>Eucrisa</p> <ul style="list-style-type: none"> • History of 28 days of therapy with a calcineurin inhibitor AND • History of 28 days of therapy with a topical steroid in the past year OR • <u>MANUAL PA</u> <p>Dupixent – Evaluated through Manual PA according to diagnosis</p> <p>Asthma – <u>MANUAL PA</u></p> <p>Atopic Dermatitis – <u>MANUAL PA</u></p> <p>Nasal Polyposis – <u>MANUAL PA</u></p>
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS <small>DUR+</small>			
	acebutolol atenolol bisoprolol metoprolol metoprolol ER nadolol nebivolol <small>Step Edit</small> pindolol propranolol propranolol ER	AZSRAZYO SPRINKLES (ranolazine) BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (bextaxolol)	<p>Nebivolol</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 preferred agent in the past 6 months <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR

41

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	sotalol	LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) SOTYLIZE (sotalol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days
BETA- AND ALPHA-BLOCKERS			
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	<p>Coreg CR</p> <ul style="list-style-type: none"> Documented diagnosis for hypertension AND Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
BETA BLOCKER/DIURETIC COMBINATIONS			
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ timolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
ANTIANGINALS			

42

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		RANEXA (ranolazine) ranolazine	Ranexa <ul style="list-style-type: none"> Documented diagnosis of angina AND 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR 90 consecutive days on the requested agent in the past 105 days
SINUS NODE AGENTS			
		CORLANOR (ivabradine)	Corlanor - MANUAL PA
BILE SALTS			
	ursodiol	ACTIGALL (ursodiol) BYLVAY (odevixibat) CHENODAL (chenodiol) CHOLBAM (cholic acid) LIVMARLI (maralixibat) OCALIVA (obeticholic acid) URSO (ursodiol) URSO FORTE (ursodiol)	
BLADDER RELAXANT PREPARATIONS <small>DUR+</small>			
	oxybutynin ER oxybutynin IR solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months

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		GEMTESA (vibegron) MYRBETRIQ ER (mirabegron) MYRBETRIQ granules (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER TOVIAZ (fesoterodine fumarate) trospium trospium ER VESICARE (solifenacin) VESICARE LS Suspension (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS <small>DUR+</small>			
	BISPHOSPHONATES		Non-Preferred Criteria <ul style="list-style-type: none">• Documented diagnosis for osteoporosis or osteopenia AND• Have tried 2 different preferred agents in the past 6 months
	alendronate ibandronate risedronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate DR Tablet	
	OTHERS		
		calcitonin salmon EVENITY (romosozumab-aqqg) EVISTA (raloxifene)	

44

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		FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	
BPH AGENTS <small>DUR+</small>			
	ALPHA BLOCKERS		Female <ul style="list-style-type: none">• Cardura, Flomax, Proscar, terazosin, or Uroxatral AND• Documented diagnosis based on a State accepted diagnosis Non-Preferred Criteria - MALE <ul style="list-style-type: none">• Have tried 2 different preferred agents in the past 6 months OR• 90 consecutive days on the requested agent in the past 105 days
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	finasteride	AVODART (dutasteride) dutasteride PROSCAR (finasteride)	
	PDE5 INHIBITORS		
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
	ANTICHOLINERGICS & COPD AGENTS		

45

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	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) LONHALA MAGNAIR (glycopyrrolate) SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) ^{DUR} TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	Minimum Age Limit 6 years – Spiriva Respimat Spiriva Respimat <ul style="list-style-type: none"> Automatic approval for ≥ 6 years with a diagnosis of asthma
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS			
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) ^{DUR+} STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS			
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	
BRONCHODILATORS, BETA AGONIST			
INHALERS, SHORT-ACTING			
	PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	albuterol HFA levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) XOPENEX HFA (levalbuterol) ^{DUR+}	Minimum Age Limit <ul style="list-style-type: none"> 4 years - Xopenex HFA Xopenex HFA <ul style="list-style-type: none"> 1 claim for a preferred albuterol inhaler in the past 30 days ProAir Digihaler

46

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	INHALERS, LONG ACTING ^{DUR+}		<ul style="list-style-type: none"> Requires clinical review
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)	ARCAPTA (indacaterol)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 4 years – Serevent 18 years – Arcapta, Striverdi Respimat <p>Arcapta & Striverdi Respimat</p> <ul style="list-style-type: none"> Documented diagnosis of COPD AND Have tried 1 preferred agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
	INHALATION SOLUTION ^{DUR+}		
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 6 years – Xopenex 18 years – Brovana, Perforomist <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> 1 claim for a different preferred agent in the past 6 months OR 3 claims with the requested agent in the past 105 days <p>Xopenex</p>

47

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			<ul style="list-style-type: none">1 claim for a preferred albuterol in the past 30 days
	ORAL		
	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS ^{DUR+}			
	SHORT-ACTING		<p>Quantity Limit - nimodipine</p> <ul style="list-style-type: none">252 tablets/ 21 days2520 mL/21 days <p>Non-Preferred Criteria</p> <ul style="list-style-type: none">Have tried 2 different preferred <u>Short Acting</u> CCB agents in the past 6 months OR90 consecutive days on the requested agent in the past 105 days <p>nimodipine</p> <ul style="list-style-type: none">Documented diagnosis of subarachnoid hemorrhage in the past 45 days ANDDuration of therapy limited to 21 days
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	
	LONG-ACTING		

48

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	amlodipine DILT XR 24 HR Caps (diltiazem) diltiazem ER Cap 24 HR (generic Cardizem CD) diltiazem ER Cap 24 HR felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) DILACOR XR (diltiazem) diltiazem ER Cap 12 HR diltiazem ER Tab 24 HR KATERZIA (amlodipine) nisoldipine NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred <u>Long Acting</u> CCB agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
CALORIC AGENTS			
	BOOST (includes all Boost) BREAKFAST ESSENTIALS BRIGHT BEGINNINGS DUOCAL ENSURE GLUCERNA NUTREN (includes all Nutren) OSMOLITE PEDIASURE PROMOD RESOURCE	All other products (caloric /nutritional agents) not listed as preferred will require a manual prior authorization.	Non-Preferred Agents - <u>MANUAL PA</u>

49

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	SCANDISHAKE TWOAL HN		
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)			
	BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
	amoxicillin/clavulanate amoxicillin/clavulanate XR	AUGMENTIN 125 and 250 Suspension (amoxicillin/clavulanate) AUGMENTIN (amoxicillin/clavulanate) Tablets AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	
	CEPHALOSPORINS – First Generation ^{DUR+}		Non-Preferred Criteria – all generations • Have tried 2 different preferred agents in the past 6 months
	cefadroxil cephalexin capsules cephalexin suspensio	cephalexin tablets DAXBIA (cephalexin) KEFLEX (cephalexin)	
	CEPHALOSPORINS – Second Generation ^{DUR+}		Maximum Age Limit • 18 years – cefdinir suspension
	cefaclor capsules cefprozil cefuroxime tablets	cefaclor ER cefaclor suspension cefuroxime suspension CEFTIN (cefuroxime)	
	CEPHALOSPORINS – Third Generation ^{DUR+}		
	cefdinir suspension cefdinir capsules cefprozime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefprozime)	

50

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COLONY STIMULATING FACTORS			
	NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim) ZIEXTENZO (pegfilgrastim-bmez)	FULPHILA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim)	
CYSTIC FIBROSIS AGENTS ^{DUR+}			
	tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistmethate COLY-MYCIN M (colistimethate sodium) KALYDECO (ivacaftor) KITABIS (tobramycin) ORKAMBI (lumacaftor/ivacaftor) PULMOZYME (dornase alfa) SYMDEKO (tezacaftor/ivacaftor) TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin (generic Bethkis) tobramycin (generic Kitabis) TRIKAFTA (elexacaftor/ tezacaftor/ivacaftor)	Minimum Age Limit <ul style="list-style-type: none"> • 3 months – Pulmozyme • 4 months – Kalydeco Granules • 2 years – Coly-Mycin M, Orkambi Granules • 6 years – Bethkis, Kalydeco tablet, Kitabis, Orkambi 100/125mg tablet, Symdeko, TOBI, TOBI Podhaler, Trikafta • 7 years – Cayston • 12 years – Orkambi 200/125mg tablet • 18 years - Bronchitol Maximum Age Limit <ul style="list-style-type: none"> • 5 years – Kalydeco and Orkambi Granules

51

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			<p>All Agents</p> <ul style="list-style-type: none"> Documented diagnosis Cystic Fibrosis <p>Colistimethate</p> <ul style="list-style-type: none"> Documented diagnosis of Cystic Fibrosis OR Requires clinical review <p>Kalydeco – MANUAL PA Orkambi – MANUAL PA Symdeko – MANUAL PA Trikafta – MANUAL PA</p> <p>TOBI Podhaler</p> <ul style="list-style-type: none"> Requires clinical review
CYTOKINE & CAM ANTAGONISTS^{DUR+}			
	ACTEMRA SYRINGE (tocilizumab) ACTEMRA VIAL(tocilizumab) AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) methotrexate ORENCIA CLICKJET(abatacept) ORENCIA VIAL(abatacept) OTEZLA (apremilast) SIMPONI (golimumab)	ACTEMRA ACTPEN (tocilizumab) ARCALYST (rilonacept) CIMZIA (certolizumab) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) INFLECTRA (infliximab) KEVZARA (sarilumab) OLUMIANT (baricitinib) ORENCIA SYRINGE (abatacept)	<p>All preferred agents are subject to approved age and documented diagnosis for appropriate indication.</p> <p>Cosentyx</p> <ul style="list-style-type: none"> Age ≥ 6 years AND Documented diagnosis of plaque psoriasis AND Have tried 90 days therapy with both Enbrel and Taltz OR Age ≥ 18 years AND

52

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	TALTZ (ixekizumab) XELJANZ IR (tofacitinib)	OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) STELARA (ustekinumab) TREMFA (guselkumab) TREXALL (methotrexate) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib)	<ul style="list-style-type: none"> Documented diagnosis of ankylosing spondylitis, plaque psoriasis, or psoriatic arthritis AND Have tried 90 days therapy with both Humira and Taltz OR All other indications evaluated through clinical review <p>All other Non-Preferred Agents</p> <ul style="list-style-type: none"> Require clinical review <p>IV Administered Agents</p> <ul style="list-style-type: none"> Require clinical review
ERYTHROPOIESIS STIMULATING PROTEINS ^{DUR+}			
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) PROCRT (rHuEPO)	<p>Mircera</p> <ul style="list-style-type: none"> Documented diagnosis chronic renal failure in the past 2 years <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of cancer or chronic renal failure OR Antineoplastic therapy in the past 6 months AND Trial of a preferred Retacrit or Epopen in the past 6 months OR 1 claim for the requested agent in the past 105 days

53

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FACTOR DEFICIENCY PRODUCTS			
	FACTOR VIII		
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE	ADYNOVATE ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	
	FACTOR IX		
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
	OTHER FACTOR PRODUCTS		

54

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2023

Version 2023.1

Updated:09-20-2022

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	COAGADEX FIBRYGA HEMLIBRA ^{DUR+} RIASTAP	CORIFACT NOVOSEVEN RT SEVENFACT TRETEN	Hemlibra • 1 claim with the requested agent in the past 105 days • MANUAL PA – new patients
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS			
	duloxetine gabapentin pregabalin SAVELLA (milnacipran)	CYMBALTA (duloxetine) ^{DUR+} DRIZALMA SPRINKLES (duloxetine DR) duloxetine DR GRALISE (gabapentin) HORIZANT (gabapentin) IRENKA (duloxetine) ^{DUR+} LYRICA (pregabalin) LYRICA CR (pregabalin) NEURONTIN (gabapentin) pregabalin ER	Cymbalta and Irenka (see Antidepressant, Other) Minimum Age Limit – automatic approval for ages 7-17 with a diagnosis of GAD (Generalized Anxiety Disorder) for preferred duloxetine
FLUOROQUINOLONES ^{DUR+}			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delafloxacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution	Non-Preferred Criteria • 1 claim for a preferred agent in past 30 days Cipro Suspension for age < 12 years • Anthrax infection or exposure OR • Cystic Fibrosis OR • Pneumonic plague OR tularemia AND history of doxycycline in the past 3 months OR

55

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		moxifloxacin NOROXIN (norfloxacin) ofloxacin	<ul style="list-style-type: none"> 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months <ul style="list-style-type: none"> Penicillin, 2nd or 3rd generation cephalosporin, or macrolide <p>Levaquin solution for age < 12 years</p> <ul style="list-style-type: none"> Anthrax infection or exposure OR 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months <ul style="list-style-type: none"> Penicillin, 2nd or 3rd generation cephalosporin, or macrolide <p>AND</p> <ul style="list-style-type: none"> Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			
	CONDYLOX (podofilox) ^{Age Edit} imiquimod ^{Age Edit} podofilox ^{Age Edit}	ALDARA (imiquimod) ^{Age Edit} CARAC (fluorouracil) diclofenac 3% gel EFUDEX (fluorouracil) fluorouracil 0.5% cream fluorouracil 5% cream	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 12 years – Aldara, Zyclara 18 years – Condylox, Picato, Veregen

56

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		PICATO (ingenol) ^{Age Edit} SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) ^{Age Edit} ZYCLARA (imiquimod) ^{Age Edit}	
GLUCOCORTICOIDS (Inhaled) ^{DUR+}			
	GLUCOCORTICOIDS		
	ASMANEX TWISTHALER (mometasone) budesonide 0.25mg and 0.5mg FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide) QVAR REDHALER (beclomethasone dipropionate)	ALVESCO (ciclesonide) ARMONAIR Digihaler (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide 1mg PULMICORT (budesonide) Respules	Non-Preferred Criteria <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 preferred agent in the past 6 months ArmonAir Digihaler <ul style="list-style-type: none"> • Requires clinical review <u>NOTE:</u> Institutional sized products are Non-Preferred
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) fluticasone/salmeterol (generic ADVAIR) fluticasone/salmeterol (generic AIRDUO) SYMBICORT (budesonide/formoterol)	AIRDUO Digihaler (fluticasone/salmeterol) AIRDUO Respiclick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol WIXELA INHUB (fluticasone/salmeterol)	Non-Preferred Criteria <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 2 different preferred agents in the past 6 months AirDuo Digihaler <ul style="list-style-type: none"> • Requires clinical review

57

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GI ULCER THERAPIES			
	H2 RECEPTOR ANTAGONISTS		Prilosec suspension • Automatic approval for 0 - 2 years
	cimetidine solution famotidine solution famotidine tablets nizatidine solution	AXID (nizatidine) cimetidine tablets nizatidine tablets PEPCID (famotidine)	
	PROTON PUMP INHIBITORS		
	esomeprazole magnesium DR Capsule NEXIUM PACKET (esomeprazole) omeprazole Rx pantoprazole	ACIPHEX SPRINKLE (rabeprazole) ACIPHEX Tablet (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium DR Capsule lansoprazole Rx NEXIUM Rx DR Capsule (esomeprazole) omeprazole sod. bicarb. PREVACID Rx (lansoprazole) PREVACID SOLU-TAB (lansoprazole) PRILOSEC RX (omeprazole) PRILOSEC SUSPENSION (omeprazole) PROTONIX DR (pantoprazole) PROTONIX PACKET (pantoprazole) rabeprazole	
	OTHER		
	misoprostol sucralfate suspension sucralfate tablet	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTEC (misoprostol)	

58

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		DARTISLA ODT (glycopyrrolate)	
GROWTH HORMONE DUR+			
	NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	GENOTROPIN (somatropin) HUMATROPE (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBTIVE (somatropin)	<p>All Agents for Age \geq 18 years</p> <ul style="list-style-type: none"> Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis OR Documented procedure of cranial irradiation <p>All Agents for Age < 18 years</p> <ul style="list-style-type: none"> Documented diagnosis of idiopathic short stature AND Documented approvable pediatric diagnosis OR Documented approvable pediatric diagnosis <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 1 preferred agent in the past 6 months OR 84 consecutive days on the requested agent in the past 105 days
H. PYLORI COMBINATION TREATMENTS			
	PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	lansoprazole, amoxicillin, clarithromycin	<p>Quantity Limit</p> <ul style="list-style-type: none"> 1 treatment course/year

59

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		OMECLAMOX (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin)	
HEPATITIS B TREATMENTS			
	entecavir EPIVIR HBV SOLUTION (lamivudine) lamivudine HBV tenofovir disoproxil fumarate	adefovir dipivoxil BARACLUDE (entecavir) EPIVIR HBV TABLET (lamivudine) HEPSERA (adefovir dipivoxil) TYZEKA (telbivudine) VEMLIDY (tenofovir alafenamide fumarate) VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS			
	MAVYRET (glecaprevir/pibrentasvir) ∞ MAVYRET PELLETS (glecaprevir/pibrentasvir)∞ PEGASYS (peginterferon alfa-2a) PEG-INTRON (peginterferon alfa-2b) ribavirin tablets sofosbuvir/velpatasvir∞	COPEGUS (ribavirin) DAKLINZA (daclatasvir) ∞ EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir) ∞ ledipasvir/sofosbuvir∞ MODERIBA (ribavirin) OLYSIO (simeprevir) REBETOL (ribavirin) RIBASPHERE (ribavirin) RIBASPHERE RIBAPAK DOSEPACK (ribavirin) ribavirin capsules SOVALDI (sofosbuvir)∞ TECHNIVIE (ombitasvir/paritaprevir/ritonavir) VIEKIRA (ombitasvir/paritaprevir/ritonavir)	Daklinza, Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier • Require clinical review <u>Note:</u> Epclusa, Harvoni, Mavyret and Sovaldi have FDA pediatric indications

60

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		VIEKIRA XR (ombitasvir/paritaprevir/ritonavir) VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ∞ ZEPATIER (elbasvir/grazoprevir) ∞	
HEREDITARY ANGIOEDEMA			
		BERINERT (C1 esterase inhibitor) CINRYZE VIAL (C1 esterase inhibitor) FIRAZYR SYRINGE (icatibant acetate) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR VIAL (ecallantide) ORLADEYO (berotralstat hydrochloride) RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT ^{DUR+}			
	allopurinol colchicine tablet probenecid probenecid/colchicine	colchicine capsule COLCRYS (colchicine) febuxostat LOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
HYPOGLYCEMIA TREATMENT, GLUCAGON			
	BAQSIMI (glucagon) ^{Step Edit} glucagen vial glucagon labeler 00002 ZEGALOGUE (dasiglucagon) ^{Step Edit}	glucagon kit (labelers 63323, 00548) GVOKE (glucagon)	Minimum Age Limit • 2 years – Gvoke • 4 years – Baqsimi • 6 years – Zegalogue

61

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			<p>Quantity Limit</p> <ul style="list-style-type: none"> • 2 packs/31 days – Baqsimi • 2 syringes/31 days – Gvoke, Zegalogue • 2 kits/31 days – Glucagon <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 preferred branded glucagon in the past 30 days <p>Baqsimi</p> <ul style="list-style-type: none"> • Have tried 1 different preferred glucagon in the past 365 days OR • 1 claim with Baqsimi in the past 365 days <p>Zegalogue</p> <ul style="list-style-type: none"> • Have tried 1 different preferred glucagon in the past 365 days OR • 1 claim with Zegalogue in the past 30 days
HYPOGLYCEMICS, BIGUANIDES ^{DUR+}			
	metformin HCL tablet metformin HCL ER 24HR tablet (generic GlucophageXR)	FORTAMET ER GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) metformin 24HR (generic Fortamet) metformin 24HR (generic Glumetza) RIOMET SOLUTION* (metformin)	<ul style="list-style-type: none"> • Clinical review required for addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> ◦ Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days

62

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			<ul style="list-style-type: none"> o 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes <p>Riomet Solution</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days
HYPOGLYCEMICS, DPP4s and COMBINATON DUR+			
	JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSENI (alogliptin/pioglitazone)	<ul style="list-style-type: none"> • Clinical review required with concomitant use of GLP-1 products in the past 30 days OR • Addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> o Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days o 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes <p>Kombiglyze XR and Onglyza</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS DUR+			

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	BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYDUREON BCISE (exenatide) MOUNJARO (tirzepatide) OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLIN (pramlintide) XULTOPHY (insulin degludec/ liraglutide)	<ul style="list-style-type: none"> Clinical review required with concomitant use of DPP-4 product in the past 30 days OR Addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes <p>Symlin is excluded from all criteria</p>
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS ^{DUR+}			
	HUMULIN N, R, 70/30 VIAL ^{OTC} (insulin) HUMULIN R U500 KWIKPEN HUMULIN R U500 VIAL (insulin) HUMALOG MIX 50/50 VIAL HUMALOG MIX 75/25 VIAL insulin aspart insulin aspart flexpen insulin aspart mix insulin aspart mix flexpen Insulin lispro insulin lispro jr kwikpen insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine)	AFREZZA (insulin) ADMELOG (insulin lispro) APIDRA (insulin glulisine) APIDRA SOLOSTAR (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG JR (insulin lispro) HUMALOG KWIKPEN U100 (insulin lispro) HUMALOG KWIKPEN U200 (insulin lispro) HUMALOG MIX KWIKPEN (insulin lispro/ lispro protamine) HUMALOG MIX VIAL (insulin lispro/ lispro protamine) HUMALOG VIAL (insulin lispro)	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of Diabetes Mellitus AND Have tried 1 preferred product in the past 6 months OR 1 claim with the requested agent in the past 105 days

64

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	LEVEMIR FLEXPEN & VIAL (insulin detemir) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	HUMULIN N, 70/30 KWIKPEN (insulin) ^{OTC} insulin glargine LYUMJEV KWIKPEN (insulin lispro) LYUMJEV VIAL (insulin lispro) NOVOLIN N, R, 70/30 FLEXPEN (insulin) ^{OTC} NOVOLIN N, R, 70/30 VIAL (insulin) ^{OTC} NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	
HYPOGLYCEMICS, MEGLITINIDES ^{DUR+}			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	<ul style="list-style-type: none"> • Clinical review required for addition of a fourth concurrent oral agent in a different drug class <ul style="list-style-type: none"> ○ Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days ○ 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS ^{DUR+}			
	HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS		

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	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	<ul style="list-style-type: none">• Clinical review required for addition of a fourth concurrent oral agent in a different drug class<ul style="list-style-type: none">○ Concurrent therapy with the incoming claim is defined as 20 or more days' supply of the drug in the past 30 days○ 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS			
	INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, TZDS			
THIAZOLIDINEDIONES			<ul style="list-style-type: none">• Clinical review required for addition of a fourth concurrent oral agent in a different drug class<ul style="list-style-type: none">○ Concurrent therapy with the incoming claim is defined as 20
	pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	

66

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			<ul style="list-style-type: none"> or more days' supply of the drug in the past 30 days 2-drug combination agents count as 2 classes and 3-drug combination agents count as 3 classes
TZD COMBINATIONS			
	pioglitazone/metformin	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUSMET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride	
IDIOPATHIC PULMONARY FIBROSIS ^{DUR+}			
	OFEV (nintedanib) pirfenidone	ESBRIET (pirfenidone)	All Agents <ul style="list-style-type: none"> Documented diagnosis Idiopathic Pulmonary Fibrosis
IMMUNOSUPPRESSIVE (ORAL) ^{DUR+}			
	AZASAN (azathioprine) azathioprine CELLCEPT (mycophenolate) cyclosporine cyclosporine modified GENGRAF (cyclosporine) IMURAN (azathioprine) mycophenolic acid mycophenolate mofetil	ASTAGRAF XL (tacrolimus) ENVARSUS XR (tacrolimus) HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) PROGRAF (tacrolimus) REZUROCK (belumosudil)	Minimum Age Limit <ul style="list-style-type: none"> 13 years - Rapamune 18 years - Zortress Astagraf, Cellcept, Envarsus XR, Hecoria, Prograf <ul style="list-style-type: none"> Documented diagnosis for heart transplant, kidney transplant, liver transplant, or a State accepted diagnosis

67

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	NEORAL (cyclosporine) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine) sirolimus tacrolimus ZORTRESS (everolimus)		<p>Azasan</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant, RA, or a State accepted diagnosis <p>Gengraf, Neoral, Sandimmune</p> <ul style="list-style-type: none"> Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State accepted diagnosis OR Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy <p>Myfortic</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant or psoriasis <p>Rapamune</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant <p>Zortress</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant or liver transplant
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF	ASCENIV CABLIVI CUTAQUIG	

68

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	GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMMAKED GAMUNEX-C HIZENTRA HYQVIA PANZYGA PRIVIGEN XEMBIFY	CUVITRU GAMMAPLEX OCTAGAM	
IMMUNOLOGIC THERAPIES FOR ASTHMA			
	DUPIXENT (dupilumab)* FASENRA PEN AUTOINJECTOR (benralizumab)* XOLAIR SYRINGE (omalizumab)	NUCALA AUTOINJECTOR (mepolizumab)* NUCALA SYRINGE (mepolizumab)* TEZSPIRE (tezepelumab)	<p>Minimum Age Limit 12 years – Fasenra pen, Nucala autoinjector, Nucala syringe</p> <p>Nonpreferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of severe persistent asthma AND • 90 days therapy with an ICS/LABA combination product in the past 120 days OR • 90 days therapy with both an ICS and a LABA or a leukotriene modifier in the past 120 days AND • 2 claims for at least 3 days each with an oral corticosteroid in the past 365 days AND • 1 claim with an ICS/LABA combination product in the past 30 days OR

69

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			<ul style="list-style-type: none"> 1 claim with both an ICS and a LABA or a leukotriene modifier in the past 30 days AND No concurrent therapy with a different asthma immunologic therapy <p>Dupixent – MANUAL PA</p>
INTRANASAL RHINITIS AGENTS			
	ANTICHOLINERGICS		
	ipratropium	ATROVENT (ipratropium)	
	ANTI-HISTAMINES		
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
	ANTI-HISTAMINE/CORTICOSTEROID COMBINATION SmartPA		
		DYMISTA (azelastine/fluticasone) TICALAST (azelastine/fluticasone)	
	CORTICOSTEROIDS SmartPA		
	fluticasone ^{Rx Only}	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis for allergic rhinitis AND Have tried 1 different preferred agent in the past 6 months

70

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		TICANASE KIT (flonase kit) triamcinolone VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	
IRON CHELATING AGENTS			
	deferasirox all strengths (all labelers except those listed as non-preferred) FERRIPROX (deferiprone)	deferasirox (labeler 00093, 16714, 45963, 62332) EXJADE (deferasirox) JADENU (deferasirox) JADENU SPRINKLES (deferasirox)	Jadenu – MANUAL PA
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED GI AGENTS ^{DUR+}			
IRRITABLE BOWEL SYNDROME CONSTIPATION			
	AMITIZA (lubiprostone) LINZESS 145mcg, 290mcg (linaclotide) MOVANTIK (naloxegol)	IBSRELA (tenapanor) LINZESS 72mcg (linaclotide) linaclotide lubiprostone MOTEGRITY (prucalopride) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod)	Minimum Age Limit All Subclasses <ul style="list-style-type: none"> • 18 years – except Bentyl, Gattex, Levsin Gender Limit <ul style="list-style-type: none"> • Female – Amitiza 8mcg Chronic Idiopathic Constipation (CIC) AMITIZA 24MCG, LINZESS 72MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE All CIC Agents <ul style="list-style-type: none"> • Documented diagnosis of CIC in the past year AND

71

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			<ul style="list-style-type: none"> No history of GI or bowel obstruction <p>Non-Preferred CIC Agents</p> <ul style="list-style-type: none"> Above CIC criteria AND 30 days of therapy with 2 preferred agents in the past 6 months OR 1 claim with the requested agent in the past 105 days <p>Irritable Bowel Syndrome – Constipation Dominant (IBS-C) AMITIZA 8MCG, LINZESS 290 MCG, TRULANCE</p> <p>All IBS-C Agents</p> <ul style="list-style-type: none"> Documented diagnosis of IBS-C in the past year AND No history of GI or bowel obstruction <p>Non-Preferred IBS-C Agents</p> <ul style="list-style-type: none"> Above IBS-C criteria AND 30 days of therapy with 2 preferred agents in the past 6 months OR 1 claim with the requested agent in the past 105 days <p>Opioid Induced Constipation (OIC) AMITIZA 24MCG, MOVANTIK, RELISTOR, SYMPROIC</p>

72

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			<p>All OIC Agents</p> <ul style="list-style-type: none"> Documented diagnosis of OIC in the past year AND 1 claim for an opioid in the past 30 days AND No history of GI or bowel obstruction AND Documented diagnosis of chronic pain in the past year <p>Non- Preferred OIC Agents</p> <ul style="list-style-type: none"> Above OIC criteria AND 30 days of therapy with 2 preferred agents in the past 6 months OR 1 claim with the requested agent in the past 105 days <p>Relistor Injection</p> <ul style="list-style-type: none"> Above OIC criteria AND Documented diagnosis of active cancer in the past year AND Documented diagnosis of palliative care in the past 6 months <p>Viberzi</p> <ul style="list-style-type: none"> Documented diagnosis of Irritable Bowel Syndrome – Diarrhea Dominant (IBS-D) in the past year AND
	IRRITABLE BOWEL SYNDROME DIARRHEA		
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	

73

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			<ul style="list-style-type: none"> • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Lotronex</p> <ul style="list-style-type: none"> • 1 claim for the requested agent in the past 105 days OR • MANUAL PA - All new patients require manual review <p>Xifaxan - (see Antibiotics, GI)</p>
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS			
		FULYZAQ (crofelemer) GATTEX (teduglutide) MYTESI (crofelemer) NUTRESTORE POWDER PACK (glutamine) XERMELO (telotristat ethyl) ZORBTIVE (somatropin)	<p>Carcinoid Syndrome Agent XERMELO</p> <ul style="list-style-type: none"> • Documented diagnosis of carcinoid syndrome in the past year AND • 1 claim for a somatostatin analog in the past 30 days <p>HIV/AIDS Non-infectious Diarrhea FULYZAQ, MYTESI</p> <ul style="list-style-type: none"> • Documented diagnosis of HIV/AIDS in the past year AND • Documented diagnosis of non-infectious diarrhea in the past year AND • 1 claim for an antiretroviral in the past 30 days

74

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			<p>Short Bowel Syndrome (SBS) GATTEX, NUTRESTORE, ZORBTIVE Gattex or Zorbtive</p> <ul style="list-style-type: none"> 1 claim for the requested agent in the past 105 days OR All new patients require clinical review <p>Nutrestore</p> <ul style="list-style-type: none"> Requires clinical review
LEUKOTRIENE MODIFIERS <small>DUR+</small>			
	montelukast granules montelukast tablets zafirlukast	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast) SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 12 years – Zyflo & Zyflo CR <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
LIPOTROPICS, OTHER (NON-STATINS) <small>DUR+</small>			
	ACL INHIBITORS AND COMBINATIONS		
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	<p>Nexletol and Nexlizet</p> <ul style="list-style-type: none"> Requires clinical review
	ANGIOPOIETIN LIKE 3 INHIBITORS		

75

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		EVKEEZA (evinacumab-dgnb)	
	BILE ACID SEQUESTRANTS		
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	<p>All Agents, All Sub-Classes both Preferred (exception is Zetia) and Non-Preferred</p> <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 statin or statin combination agent in the past year OR • One of the following exceptions <ul style="list-style-type: none"> ◦ Welchol AND Type 2 diabetes AND 1 preferred oral antidiabetic agent in the past 180 days OR ◦ Pregnant female OR ◦ Documented diagnosis of liver disease OR ◦ Documented diagnosis for hypertriglyceridemia OR ◦ Clinical justification a statin or statin combination product cannot be used <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
	OMEGA-3 FATTY ACIDS		

76

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

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	omega 3 acid ethyl esters	icosapent LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	Non-Preferred Criteria • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
	CHOLESTEROL ABSORPTION INHIBITORS		
	ezetimibe	ZETIA (ezetimibe)	Zetia does not have to meet the trial of 1 statin or statin combination agent in the past year
	FIBRIC ACID DERIVATIVES		
	fenofibrate nanocrystallized gemfibrozil	ANTARA (fenofibrate, micronized) fenofibrate 40mg tablet fenofibrate, micronized fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	Fibric Acid Derivative Non-Preferred Criteria • Have tried 2 different fibric acid derivatives in the past 6 months
	MTP INHIBITOR		
		JUXTAPID (lomitapide)	Juxtapid – MANUAL PA
	APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR		
		KYNAMRO (mipomersen)	Kynamro – MANUAL PA
	NIACIN		

77

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	niacin ER NIACOR (niacin)	NIASPAN (niacin)	Non-Preferred Criteria • Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months
PCSK-9 INHIBITOR			
	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	Praluent - MANUAL PA Repatha - MANUAL PA
LIPOTROPICS, STATINS ^{DUR+}			
	STATINS		
	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	Simvastatin 80mg • 12 months of therapy with simvastatin 80mg AND • NO myopathy contraindication Non-Preferred Criteria • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
	STATIN COMBINATIONS		
	ezetimibe/simvastatin SIMCOR (simvastatin/niacin)	ADVICOR (lovastatin/niacin) atorvastatin/amlodipine CADUET (atorvastatin/amlodipine)	Non-Preferred Criteria

78

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		LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	<ul style="list-style-type: none">Have tried 2 different preferred statin or statin combination agents in the past 6 months OR90 consecutive days on the requested agent in the past 105 days
MISCELLANEOUS BRAND/GENERIC			
	EPINEPHRINE		Quantity Limit <ul style="list-style-type: none">2 kits/31 days
	epinephrine autoinject pens (labeler 49502) SYMJEPI (epinephrine)	ADRENALICK (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	
	MISCELLANEOUS		
	alprazolam CARBAGLU (carglumic acid) hydroxyzine hcl syrup hydroxyzine hcl tablets hydroxyzine pamoate MAKENA (hydroxyprogesterone caproate) megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	alprazolam ER CAMZYOS (mavacamten) carglumic acid EVRYSDI (risdiplam) hydroxyprogesterone caproate KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	Alprazolam ER CUMULATIVE quantity limit <ul style="list-style-type: none">31 tablets/31 days Evrystdi - MANUAL PA
	ALLERGEN EXTRACT IMMUNOTHERAPY		
		GRASTEK ORALAIR PALFORZIA	

79

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		RAGWITEK	
	SUBLINGUAL NITROGLYCERIN		
	nitroglycerin lingual 12gm nitroglycerin sublingual NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm NITROMIST (nitroglycerin)	
MOVEMENT DISORDER AGENTS <small>DUR+</small>			
	AUSTEDO (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine (all labelers except those listed as non-preferred)	tetrabenazine (labeler 47335, 51224, 60505, 68180, 686820) XENAZINE (tetrabenazine)	Austedo <ul style="list-style-type: none"> Documented diagnosis of Huntington's chorea OR Documented diagnosis of tardive dyskinesia AND 90 days therapy with Austedo in the past 105 days OR MANUAL PA Ingrezza <ul style="list-style-type: none"> Documented diagnosis of tardive dyskinesia AND 90 days therapy with Ingrezza in the past 105 days OR MANUAL PA
MULTIPLE SCLEROSIS AGENTS <small>DUR+</small>			
	AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b)	AMPYRA (dalfampridine) BAFIERTAM (monomethyl fumarate) COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b)	All Agents <ul style="list-style-type: none"> Documented diagnosis of multiple sclerosis Non-Preferred Criteria

80

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	COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a) TYSABRI (natalizumab)	glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	<ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 3 claims with the requested agent in the last 105 days <p>Kesimpta, Ponvory and Zeposia</p> <ul style="list-style-type: none"> Requires clinical review <p>Mavenclad – MANUAL PA</p> <p>Mayzent – MANUAL PA</p> <p>Ocrevus – MANUAL PA</p>
MUSCULAR DYSTROPHY AGENTS			
		AMONDYS 45 (casimersen) EMFLAZA (deflazacort) EXONDYS 51 (eteplirsen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	<p>Emflaza – MANUAL PA</p> <p>Exondys – MANUAL PA</p> <p>Viltepso – MANUAL PA</p> <p>Vyondys – MANUAL PA</p>
NSAIDS ^{DUR+}			
	NON-SELECTIVE		
	diclofenac EC diclofenac IR diclofenac SR etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension ^{OTC} indomethacin	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac) DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months

81

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	ketoprofen ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER ketoprofen ER LOFENA(diclofenac potassium) meclofenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen) oxaprozin PONSTEL (mefenamic acid) PROFENO (fenoprofen) RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol	Non-Preferred Criteria • Have tried 2 different preferred non-selective or NSAID/GI protectant

82

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		DUEXIS (ibuprofen/famotidine) VIMOVO (naproxen/esomeprazole)	combination agents in the past 6 months
COX II SELECTIVE			
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	Non-Preferred Criteria – COX II <ul style="list-style-type: none"> Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis AND 90 consecutive days on the requested agent in the past 105 days OR Have tried 1 preferred COX-II Selective and 1 preferred Non-Selective Agent OR Have tried 1 preferred COX-II Selective agent and a documented diagnosis of GI Bleed, GERD, PUD, GI Perforation, or Coagulation Disorder
OPHTHALMIC ANTIBIOTICS			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin ciprofloxacin erythromycin GENTAK Ointment (gentamicin) gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN Ointment (ciprofloxacin) CILOXAN Solution (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin levofloxacin	

83

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	polymyxin/trimethoprim tobramycin	MOXEZA (moxifloxacin) NATACYN (natamycin) neomycin/bacitracin/polymyxin b NEO-POLYCIN (neomy/baci/polymyxin b) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBREX drops (tobramycin) TOBREX ointment (tobramycin) VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	
ANTIBIOTIC STEROID COMBINATIONS			
	BLEPHAMIDE (sulfacetamide/prednisolone) drops, oint neomycin/bacitracin/polymyxin/hc ointment neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone) drops, oint sulfacetamide/prednisolone TOBRADEX SUSPENSION/OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) tobramycin/dexamethasone	
OPHTHALMIC ANTI-INFLAMMATORIES ^{DUR+}			
	dexamethasone diclofenac difluprednate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months

84

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	FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate PRED MILD (prednisolone) VEXOL (rimexolone)	BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol) loteprednol etabonate OCUFEN (flurbiprofen) OMNIPRED (prednisolone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS ^{DUR+}			
	ALREX (loteprednol) azelastine cromolyn ketotifen ^{OTC} olopatadine 0.1% olopatadine 0.2%	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) epinastine LASTACRAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) ZERVIAE (cetirizine)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
OPHTHALMIC, DRY EYE AGENTS			

85

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	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) EYSUVIS (loteprednol etabonate) RESTASIS Multidose (cyclosporine) TYRVAYA (varaenicine) Nasal XIIDRA (lifitegrast) ^{DUR+}	Minimum Age Limit <ul style="list-style-type: none"> • 16 years – Restasis • 17 years – Xiidra • 18 years – Cequa Quantity Limit <ul style="list-style-type: none"> • 5.5 mL/31 days – Restasis Multidose • 60 units/31 days – Cequa, Restasis droperette, Xiidra Non-Preferred Criteria <ul style="list-style-type: none"> • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS ^{DUR+}			
	BETA BLOCKERS		Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol timolol drops 0.25%, 0.5%	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		

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	dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	
	COMBINATION AGENTS		
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
	PARASYMPATHOMIMETICS		
	pilocarpine	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) ISOPTO CARPINE (pilocarpine) PHOSPHOLINE IODIDE (echothiophate iodide) PILOPINE HS (pilocarpine)	
	PROSTAGLANDIN ANALOGS		
	latanoprost	bimatoprost LUMIGAN (bimatoprost) TRAVATAN Z (travoprost) travoprost XALATAN (latanoprost) XELPROS (latanoprost) VYZULTA (latanoprostene bunod) ZIOPTAN (tafluprost)	
	RHO KINASE INHIBITORS/COMBINATIONS		
	RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
	SYMPATHOMIMETICS		
	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine)	brimonidine 0.15% dipivefrin	

87

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MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 01/01/2023

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	brimonidine 0.2%	PROPINE (dipivefrin)	
OPIATE DEPENDENCE TREATMENTS			
	DEPENDENCE		
	buprenorphine/naloxone tablets naltrexone tablets SUBOXONE FIL(buprenorphine/naloxone) ^{DUR+}	buprenorphine tablets BUNAVAIL (buprenorphine/naloxone) buprenorphine/naloxone films LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine) SUBLOCADE (buprenorphine) VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)	<p><u>Buprenorphine/Naloxone and buprenorphine</u></p> <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Bunavail is preferred over Zubsolv and other generic forms of buprenorphine/naloxone <p>Bunavail <i>NOTE: Bunavail is not indicated for induction therapy</i></p> <ul style="list-style-type: none"> History of Suboxone therapy within the past 6 months OR History of Bunavail therapy within the past 3 months AND All other buprenorphine/naloxone provider summary found here <p>Probuphine – <u>MANUAL PA</u> Sublocade – <u>MANUAL PA</u> Vivitrol - <u>MANUAL PA</u></p>
	TREATMENT		
	naloxone injection NARCAN NASAL SPRAY (naloxone) KLOXXADO (naloxone)	EVZIO (naloxone) ZIMHI (naloxone)	

88

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OTIC ANTIBIOTICS			
	CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) ^{Age Edit} CORTISPORIN-TC (colistin/neomycin/ hydrocortisone) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil OTIPRIO (ciprofloxacin) OTOVEL (ciprofloxacin/fluocinolone)	Maximum Age Limit • 9 years - Cipro HC
PANCREATIC ENZYMES ^{DUR+}			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
PARATHYROID AGENTS			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	
PHOSPHATE BINDERS			
	calcium acetate ELIPHOS (calcium acetate)	AURYXIA (ferric citrate) FOSRENOL (lanthanum)	

89

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	PHOSLYRA (calcium acetate) sevelamer carbonate tablets	lanthanum PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydroxide)	
PLATELET AGGREGATION INHIBITORS ^{DUR+}			
	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline prasugrel	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/asprin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	Zontivity – MANUAL PA Non-Preferred Criteria <ul style="list-style-type: none">• Documented diagnosis AND• Have tried 2 different preferred agents in the past 6 months OR• 90 consecutive days on the requested agent in the past 105 days
PLATELET STIMULATING AGENTS			
	NPLATE (romiplostim) PROMACTA (eltrombopag olamine)	DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) PROMACTA powder pack (eltrombopag olamine) TAVALISSE (fostamatinib disodium)	
PRENATAL VITAMINS			
	COMPLETE NATAL DHA COMPLETENATE CHEW Tablet M-NATAL PLUS Tablet NESTABS DHA COMBO PKG	Products not listed are assumed to be Non-Preferred.	

90

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	NIVA PLUS Tablet PNV 29-1 Tablet PNV 95/Fe/FA Tablet (labeler 00536) PNV 137/Fe/FA Tablet (labeler 009040) PNV-DHA Softgel Capsule PRENATAL VITAMIN PLUS LOW IRON Tablet PRENATAL PLUS IRON/FA PREPLUS Ca/Fe27/FA 1 Tablet PRETAB Tablet SE-NATAL19 CHEW Tablet SE-NATAL19 Tablet THRIVITE RX Tablet TRINATAL Rx 1 Tablet VIRT C DHA Capsule VIRT-NATE DHA Softgel Capsule VP-PNV-DHA Softgel Capsule WESTAB PLUS Tablet		
PSEUDOBULBAR AFFECT AGENTS			
		NUEDEXTA (dextromethorphan/quinidine)	Non-Preferred Criteria <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days OR Documented diagnosis of Pseudobulbar Affect
PULMONARY ANTIHYPERTENSIVES^{DUR+}			
	ENDOTHELIN RECEPTOR ANTAGONIST		
	ambrisentan (all labelers except those listed as non-preferred) bosentan tablets	ambrisentan (labeler 42794, 47335, 498840) LETAIRIS (ambrisentan)* OPSUMIT (macitentan)	All PAH Agents <ul style="list-style-type: none"> Documented diagnosis of pulmonary hypertension

91

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		TRACLEER (bosentan)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 preferred PAH agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
	PDE5's		
	sildenafil (generic Revatio) tablet tadalafil	ADCIRCA (tadalafil) REVATIO (sildenafil) tablet REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 preferred PAH agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days Revatio suspension <ul style="list-style-type: none"> < 12 years of age AND Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation or history of heart transplant OR 90 consecutive days on the requested agent in the past 105 days Revatio tablets <ul style="list-style-type: none"> < 1 year of age AND Documented diagnosis of Pulmonary Hypertension, Patent

92

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			Ductus Arteriosus, or Persistent Fetal Circulation OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days OR > 1 years of age AND Have tried 1 preferred PAH agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
PROSTACYCLINS			
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 preferred PAH agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS			
		UPTRAVI (selexipag)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 1 preferred PAH agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
SOLUBLE GUANYLATE CYCLASE STIMULATORS			
		ADEMPAS (riociguat)	Adempas <ul style="list-style-type: none"> Have tried 1 preferred PAH agent in the past 6 months OR

93

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			<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days OR Clinical review required for PAH WHO Group 4
ROSACEA TREATMENTS			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion) MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADÉ (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥21 years. Other labeled indications are limited to <21 years.
SEDATIVE HYPNOTICS			
	BENZODIAZEPINES ^{DUR+}		

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	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DAYVIGO (lemborexant) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. MS DOM Opioid Initiative • Concomitant use of Opioids and Benzodiazepines Criteria details found here Quantity Limit – CUMULATIVE Quantity limit per rolling days for all strengths. <i>SmartPA will allow an early refill override for one dose or therapy change per year.</i> • 31 units/31 days - all strengths Triazolam – CUMULATIVE Quantity limit per rolling days for all strengths • 10 units/31 days • 60 units/365 days
OTHERS DUR+			
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) doxepin EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone)	Quantity Limit – CUMULATIVE Quantity limit per rolling days for all strengths. <i>SmartPA will allow an early refill override for one dose or therapy change per year.</i> • 31 units/31 days • 1 canister/31 days – Zolpimist & male • 1 canister/62 days – Zolpimist & female

95

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		ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	<ul style="list-style-type: none"> • 1 bottle/31 days (48 ml or 158 ml) – Hetlioz liquid <p>Gender and Dose Limit for zolpidem</p> <ul style="list-style-type: none"> • Female – Ambien 5mg, Ambien CR 6.25mg, Intermezzo 1.75 mg • Male – all zolpidem strengths <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p>Hetlioz capsules</p> <ul style="list-style-type: none"> • Documented diagnosis of circadian rhythm sleep disorder AND • Documented diagnosis indicating total blindness of the patient OR • Documented diagnosis of Magenis-Smith syndrome <p>Hetlioz liquid</p> <ul style="list-style-type: none"> • Documented diagnosis of Smith-Magenis syndrome AND • 3 - 15 years of age
SELECT CONTRACEPTIVE PRODUCTS			
	INJECTABLE CONTRACEPTIVES		
	medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 1 claim with the requested agent in the past 105 days

96

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		DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)	
	INTRAVAGINAL CONTRACEPTIVES		
	ANNOVERA (segesterone/ethinyl estradiol) etonogestrel/ethinyl estradiol NUVARING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid, citric acid, potassium bitartrate)	
	ORAL CONTRACEPTIVES ^{DUR+}		
	ALL CONTRACEPTIVES ARE PREFERRED EXCEPT FOR THOSE SPECIFICALLY INDICATED AS NON-PREFERRED	AMETHIA (levonorgestrel/ethinyl estradiol) AMETHYST (levonorgestrel/ethinyl estradiol) BALCOLTRA (levonorgestrel/ethinyl estradiol/iron) BEYAZ (ethinyl estradiol / drospirenone/levomefolate) CAMRESE (levonorgestrel/ethinyl estradiol) CAMRESE LO (levonorgestrel/ethinyl estradiol) GENERESS FE (norethindrone/ethinyl estradiol/fe) GIANVI (ethinyl estradiol/drospirenone) JOLESSA (levonorgestrel/ethinyl estradiol) levonorgestrel/ethinyl estradiol LO LOESTRIN FE (norethindrone/ethinyl estradiol) LOESTRIN (norethindrone acetate/ethinyl estradiol) LOESTRIN FE (norethindrone/ethinyl estradiol/iron) MINASTRIN 24 FE (norethindrone/ethinyl estradiol/iron)	

97

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		NATAZIA (estradiol valerate/dienogest) NEXTSTELLIS (drospirenone/estetrol) OCELLA (ethinyl estradiol/drospirenone) SAFYRAL (ethinyl estradiol/ drospirenone/levomefolate) SIMPESS (levonorgestrel/ethinyl estradiol) TAYTULLA (norethindrone/ethinyl estradiol/iron) TYDEMY (ethinyl estradiol/drospirenone/ levomefolate calcium) YASMIN (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	
TRANSDERMAL CONTRACEPTIVES			
	XULANE (norelgestromin and ethinyl estradiol)	ZAFEMY (norelgestromin and ethinyl estradiol) TWIRLA (levonorgestrel and ethinyl estradiol)	
SICKLE CELL AGENTS			
	DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab) ENDARI (glutamine) HYDREA (hydroxyurea) OXBRYTA (voxelotor) SIKLOS (hydroxyurea)	Endari – MANUAL PA Oxbryta – MANUAL PA
SKELETAL MUSCLE RELAXANTS ^{DUR+}			
	baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine ER) carisoprodol carisoprodol compound cyclobenzaprine 7.5mg, 15mg cyclobenzaprine ER	Non-Preferred Agents <ul style="list-style-type: none"> Documented diagnosis for an approvable indication AND Have tried 2 different preferred agents in the past 6 months

98

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		DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen) FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) LYVISPAN (baclofen granules) metaxalone NORGESIC FORTE (orphenadrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	Carisoprodol <ul style="list-style-type: none"> Documented diagnosis of acute musculoskeletal condition AND NO history with meprobamate in the past 90 days AND 1 claim for cyclobenzaprine in the past 21 days OR a documented intolerance to cyclobenzaprine AND Quantity Limit <ul style="list-style-type: none"> 18 tablets - to allow tapering off 84 tablets/6 months Carisoprodol with codeine <ul style="list-style-type: none"> Requires clinical review
SMOKING DETERRENT			
	NICOTINE TYPE		
	nicotine gum ^{OTC} nicotine lozenge ^{OTC} nicotine mini lozenge ^{OTC} nicotine patch ^{OTC}	NICODERM CQ PATCH ^{OTC} NICORETTE GUM ^{OTC} NICORETTE LOZENGE ^{OTC} NICORETTE MINI LOZENGE ^{OTC} NICOTROL INHALER CARTRIDGE NICOTROL NASAL SPRAY	
	NON-NICOTINE TYPE		

99

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	bupropion ER CHANTIX (varenicline) varenicline	ZYBAN (bupropion)	Minimum Age Limit - Chantix • 18 years Quantity Limit • 336 tablets/year – Chantix 0.5mg, 1mg tablets and continuing pack • 2 treatment courses/year – Chantix Starter Pack
STERIODS (Topical) ^{DUR+}			
	LOW POTENCY		
	CAPEX (fluocinolone) desonide hydrocortisone cr, oint, soln.	alclometasone DERMA-SMOOTH-FS (fluocinolone) DESONATE (desonide) DESOWEN (desonide) fluocinolone oil hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	Non-Preferred Criteria • Have tried 2 different preferred low potency agents in the past 6 months
	MEDIUM POTENCY		
	fluocinolone hydrocortisone mometasone cr, oint. prednicarbate cr PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone LUXIQ (betamethasone) mometasone solution	Non-Preferred Criteria • Have tried 2 different preferred medium potency agents in the past 6 months

100

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		MOMEXIN (mometasone) prednicarbate oint SYNALAR (fluocinolone)	
	HIGH POTENCY		
	amcinonide cr, lot betamethasone dipropionate cr, gel, lotion betamethasone valerate cr, lotion, oint. fluocinolone triamcinolone	amcinonide oint betameth diprop/prop gly cr, lot, oint betamethasone dipropionate oint. BETA-VAL (betamethasone valerate) desoximetasone diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) fluocinonide HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone) TRIANEX (triamcinolone) VANOS (fluocinonide)	Non-Preferred Criteria • Have tried 2 different preferred high potency agents in the past 6 months
	VERY HIGH POTENCY		
	clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate ointment halobetasol cream halobetasol ointment	BRYHALI (halobetasol) clobetasol emollient clobetasol propionate foam, ge CLOBEX (clobetasol) DIPROLENE (betamethasone diprop/prop gly) DUOBRII LOTION (halobetasol prop/tazarotene)	Non-Preferred Criteria • Have tried 2 different preferred very high potency agents in the past 6 months

101

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		halobetasol foam IMPEKLO (clobetasol) LEXETTE (halobetasol propionate) OLUX (clobetasol) OLUX-E (clobetasol) TEMOVATE Cream (clobetasol propionate) TEMOVATE Ointment (clobetasol propionate) TOVET Foam (clobetasol) ULTRAVATE Lotion (halobetasol)	
STIMULANTS AND RELATED AGENTS ^{DUR+}			
		SHORT-ACTING	
	amphetamine salt combination dexamethylphenidate IR dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT (amphetamine) FOCALIN (dexamethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 3 years - Adderall, Evekeo, Procentra, Zenzedi • 6 years – Desoxyn, Evekeo ODT, Focalin, Methylin <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Evekeo ODT <p>Quantity Limit</p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 62 tablets/31 days – Adderall, Desoxyn, Evekeo, Focalin, Methylin, Zenzedi • 310 mL/31 days – Methylin solution, Procentra

102

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			<p><u>Documented diagnosis of ADHD –</u> ALL Short Acting AGENTS</p> <p>Non-Preferred Criteria ADD/ADHD</p> <ul style="list-style-type: none"> Documented diagnosis of ADD/ADHD AND Have tried 2 different preferred Short Acting agents in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days <p><u>Documented diagnosis of narcolepsy –</u> ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI</p>
LONG-ACTING			
	amphetamine salt combination ER dexamethylphenidate ER dextroamphetamine ER DYANAVEL XR SUSPENSION(amphetamine) methylphenidate CD (generic Metadate CD) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	ADDERALL XR (amphetamine salt combination) ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphen/dexamethylphen) CONCERTA (methylphenidate) COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine) DYANAVEL XR tablet(amphetamine)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 6 years – Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta, Cotempla XR ODT, Daytrana, Dexedrine, Dyanavel XR Focalin XR, Jornay PM, Metadate, CD, methylphenidate ER 72mg, Quillichew, Quillivant XR, Ritalin LA, Vyvanse 13 years – Mydayis 16 years – Provigil

103

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		FOCALIN XR (dexamethylphenidate) JORNAY PM (methylphenidate) methylphenidate ER caps (generic Aptensio XR) methylphenidate ER (generic Relexxi) MYDAYIS (amphetamine salt combination) RELEXXI (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE CHEWABLE (lisdexamfetamine)*	<ul style="list-style-type: none"> • 18 years – Nuvigil, Sunosi <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Cotelpla XR ODT, Daytrana <p>Quantity Limit Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Adderall XR, Adhansia XR, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta 18, 27, & 54 mg, Cotelpla XR-ODT 8.6 mg, Daytrana, Dexedrine Spansule, Focalin XR, Jornay PM, Metadate CD, Methylin ER, methylphenidate ER 72mg, Nuvigil 150, 200 & 250 mg, Provigil 200mg, Quillichew, Ritalin LA & SR, Vyvanse, Sunosi • 46.5 tablets/31 days – Provigil 100 mg • 62 tablets/31 days – Concerta 36mg, Cotelpla XR-ODT 17.3 & 25.9 mg, Nuvigil 50mg • 248 mL/31 days – Dynavel XR • 372 mL/31 days – Quilivant XR <p>Documented diagnosis of ADHD – ALL Long-Acting AGENTS</p>

104

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			Non-Preferred Criteria ADD/ADHD <ul style="list-style-type: none"> Documented diagnosis of ADD/ADHD AND Have tried 2 different preferred Long-Acting agents in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days
	NARCOLEPSY		
	armodafinil modafinil SUNOSI (solriamfetol)	NUVIGIL (armodafinil) PROVIGIL (modafinil) WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (calcium, magnesium, potassium and sodium oxybates)	Documented diagnosis of narcolepsy – ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI Non-Preferred Criteria narcolepsy <ul style="list-style-type: none"> Documented diagnosis of narcolepsy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND 1 different preferred Long-Acting agent indicated for narcolepsy in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days

105

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			<p>Nuvigil</p> <ul style="list-style-type: none"> Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression <p>Provigil</p> <ul style="list-style-type: none"> Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome <p>Sunosi</p> <ul style="list-style-type: none"> Documented diagnosis of narcolepsy or obstructive sleep apnea AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months <p>Wakix</p> <ul style="list-style-type: none"> Documented diagnosis of narcolepsy with or without cataplexy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months OR

106

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			<ul style="list-style-type: none"> Documented diagnosis of narcolepsy without cataplexy or substance abuse disorder <p>Xyrem and Xywav</p> <ul style="list-style-type: none"> Requires clinical review
	NON-STIMULANTS		
	atomoxetine clonidine ER guanfacine ER <small>Step Edit</small>	INTUNIV (guanfacine ER) QELBREE (viloxazine) STRATTERA (atomoxetine)	<p>Minimum Age Limit 6 years – Intuniv, Kapvay, Qelbree, Strattera 18 years – Wakix Maximum Age Limit</p> <ul style="list-style-type: none"> 18 years – Intuniv, Kapvay, Qelbree 21 years – diagnosis of ADD/ADHD is required for Strattera <p>Quantity Limit Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> 31 tablets/31 days – Intuniv, Qelbree 100 mg, Strattera 62 tablets/31 days – Qelbree 150 mg and 200 mg, Wakix 124 tablets/31 days – Kapvay <p>Intuniv</p> <ul style="list-style-type: none"> Have tried the short acting guanfacine in the past 6 months OR

107

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			<ul style="list-style-type: none"> 1 claim for a 30-day supply with guanfacine ER in the past 105 days <p>Kapvay</p> <ul style="list-style-type: none"> Documented diagnosis of ADD or ADHD AND Have tried 1 Short or Long-Acting stimulant in the past 6 months OR Have tried 1 preferred Non-Stimulant in the past 6 months OR Have tried the short acting product in the past 6 months <p>Qelbree</p> <ul style="list-style-type: none"> Documented diagnosis of ADD or ADHD AND 1 claim for a 30-day supply with atomoxetine in the past 105 days
TETRACYCLINES ^{DUR+}			
	doxycycline hyclate caps/tabs doxycycline monohydrate caps (50mg & 100mg) minocycline caps IR tetracycline	ACTICLATE (doxycycline) ADOXA (doxycycline monohydrate) demeclocycline doxycycline hyclate (generic Doryx) doxycycline monohydrate caps (75mg & 150mg) doxycycline monohydrate tabs DORYX (doxycycline hyclate) DYNACIN (minocycline) MINOCIN (minocycline) MINOLIRA (minocycline)	<p>Non-Preferred Agents</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p>Demeclocycline</p> <ul style="list-style-type: none"> Documented diagnosis of Diabetes Insipidus or SIADH will allow automatic approval

108

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		minocycline ER minocycline tabs MONODOX (doxycycline monohydrate) NUZYRA (omadacycline tosylate) OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline) VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	
ULCERATIVE COLITIS and CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for additional agents			
	balsalazide budesonide EC mesalamine tablet (generic Apriso) sulfasalazine	ORAL APRISO (mesalamine) ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) AZULFIDINE ER (sulfasalazine) COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) ENTOCORT EC (budesonide) GIAZO (balsalazide) LIALDA (mesalamine) mesalamine tablet (generic Asacol HD) mesalamine tablet (generic Delzicol) ORTIKOS (budesonide) PENTASA 250mg (mesalamine) PENTASA 500mg (mesalamine)	Non-Preferred Criteria <ul style="list-style-type: none"> Documented diagnosis for Ulcerative Colitis AND Have tried 2 different preferred agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days Ortikos ER <ul style="list-style-type: none"> Requires clinical review

109

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		UCERIS (budesonide)	
		RECTAL	
	mesalamine suppository	CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

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PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F